prognostic number, that is, "Take this medicine for three days and call back"; or, "Wait three days and then we'll consider a different approach."

The medical fascination with three may be built out of solid clinical experience or scientific reason. But like all traditions and "routines" it deserves reexamination to be certain that we are being cost effective and efficient. It may turn out that there is a certain amount of magic in our medical three that is as mystical as the Kaballah.

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Interaction Between Valproic Acid and Phenytoin

TO THE EDITOR: I enjoyed reading the succinct and educational "Epitomes of Progress, Neurology—Important Advances in Clinical Medicine" in the October issue. Nevertheless, in her effort to be brief, Dr Doris Trauner[1] may have left room for a potentially hazardous interpretation. She states, "Valproic acid . . . decreases phenytoin concentrations, so that blood concentrations of [this medication] should be monitored closely when used in combination with [valproic acid]." From this it would not be unreasonable for the reader to make a common assumption that if the serum concentration of the interacted drug falls below the usual "therapeutic" range, the dose should be increased. It is true that the effect of the common interaction, wherein the metabolism of drug A is stimulated by drug B, can be overcome by increasing the dose of A. This remedy *cannot* be used for the phenytoin/valproic acid interaction. While total serum phenytoin may decrease with the addition of valproic acid, the fraction of remaining phenytoin not bound to plasma protein increases. The actual concentration of this free phenytoin may unpredictably decrease,[2] remain constant[3] or increase[4] from prevalproic acid levels. The paradox of this interaction has been well documented[5] and there are recommendations that phenytoin dosage not be altered on the basis of this anticipated interaction alone.[3,6] Unfortunately, monitoring total serum phenytoin concentrations as a measure of therapeutic success or impending toxicity will prove unreliable, not helpful and even misleading.

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Covert Diuretic Use and Anorexia Nervosa

TO THE EDITOR: In the October 1982 issue there appeared an article by Drs Spratt and Pont entitled "The Clinical Features of Covert Diuretic Use."[1] In this article the authors described the cases of two patients with covert diuretic abuse. Both of these patients, on the basis of the information provided in the article, should carry the psychiatric diagnosis anorexia nervosa. Most psychiatrists would immediately suspect that a person who took diuretics or laxatives (or both) covertly has an eating disorder. Indeed some of the other information provided in the article pointed strongly in that direction.

The baffling thing about the presentation to me is that these patients could be treated for "covert diuretic use" without addressing the real problem. Although it was a fine article and I am sure Bartter's syndrome is an entity I should know about, I am more sure that anorexia nervosa is something that the authors should know about.

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Non-Hodgkin's Lymphoma in Homosexual Men

TO THE EDITOR: As has been recently reported, the male homosexual population is at increased risk for certain tumors.[1] Recently, Ziegler and co-workers[2] observed another malignancy that may have an increased incidence in homosexual men. They reported four cases of a Burkitt's-like lymphoma in male homosexuals, thus adding another malignancy that may be associated with a male homosexual life-style. In the past year we have also observed two such cases of lymphoma in homosexual men:

PATIENT 1. A 29-year-old homosexual man was evaluated for increasing abdominal girth in January 1980. On physical examination an abdominal mass was found. At laparotomy, a biopsy specimen showed a Burkitt's-like lymphoma. The patient was treated with combination chemotherapy (cyclophosphamide-doxorubicin-vincristine-prednisone, or CHOP). Following an initial response complicated by the tumor lysis syndrome, the patient had progressive disease resistant to further therapy and died in March 1980.

PATIENT 2. A 27-year-old homosexual man was admitted to hospital for evaluation of an abdominal mass.

At laparotomy, a biopsy specimen of an omental node showed a Burkitt's-like lymphoma. The patient was treated with combination chemotherapy (CHOP) and remains in a remission.

Of interest, both of our patients engaged in homosexual relations with numerous partners over many years. In addition, each experimented with various street drugs. Cytomegalovirus and Epstein-Barr virus titers were elevated in both of our patients, though no further studies were carried out.

Based on the report of Ziegler and associates, as well as the additional cases observed by us, it appears that a Burkitt's-like lymphoma may occur in homosexual men. Further investigations are needed to define risk factors and develop suitable screening methods.

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California Legislation Regarding Patients With Breast Cancer

TO THE EDITOR: On October 9, 1982, a symposium titled "The Current Management of Early Breast Cancer," sponsored by Western Medical Center, St. Joseph's Hospital, and the Clinical Oncology Service of the University of California, Irvine, California College of Medicine, was held in Anaheim, California. It was evident that the best available data on treatment of breast cancer are retrospective and could be used to support widely divergent views of the basic biology and appropriate clinical approach to the disease. At the same conference a new California law requiring that physicians discuss a list of specific diagnostic and treatment options with their patients with breast cancer was discussed. However, physicians have not been provided with materials or directives for their presentation to a patient. The Honorable David Roberti, state senator and author of the law, described its origin: a woman disagreed with her physician that she needed a mastectomy, signed out of the hospital, read extensively about the disease, decided to receive radioactive implants and has subsequently done well after an unspecified period of time.

The long-range implications of legislation influencing medical practice were alluded to at the symposium. Not discussed, however, were its potential adverse effects on physician-patient communication and rapport. True, the law will protect inquisitive patients from poorly informed or inflexible physicians. However, some patients react to the news of breast cancer with shock, fear and disbelief. Overly anxious patients, hoping that their physicians will resolve uncertainties and provide firm guidance, may be immobilized by the presentation of conflicting alternatives at a time when their ability or willingness to assimilate it is limited.

Several guiding principles may help physicians in this situation. First, physicians should reassure their patients with newly diagnosed breast cancer that disagreement about treatment does not imply lack of hope and that referral to multiple specialists does not imply loss or dilution of the primary doctor-patient relationship. Second, patients who do not spontaneously request information or discuss alternatives should be encouraged in a nondirective manner to share their experiences, beliefs and fears about cancer and its treatment. In this way patients may be helped to formulate the questions that the law requests we answer, and by asking them they will indicate the proper time to present the materials. Finally, patients who become anxious when you provide the materials should be reassured that you will take as active a role as necessary in helping them decide how to proceed.

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Pulmonary Effects of Intestinal Parasites

TO THE EDITOR: During a recent one-month tour of duty at the Lyndon B. Johnson Tropical Medical Center in American Samoa, another visitor, a radiologist, showed me x-ray films of 15 children with chronic chest infiltrates. These occurred primarily in the right middle lobe and perihilar regions. In some of the children repeated x-ray studies had been done over two years showing some shifting patterns, but no resolution of pneumonia. Three had significant eosinophilia noted in their charts. In all of the children chronic coughing or wheezing had been noted. Antibiotics had had no effect.

My immediate conclusion was that most of these children were suffering from the larval migrans effects of intestinal parasites. The larvae of intestinal helminths develop in the lungs where they cause direct irritant and obstructive effects, while the worms themselves may be highly allergenic.[1] In fact, on examination of a single stool specimen for each child, seven contained eggs of either *Ascaris* or hookworms. Later specimens from the other children may show positive results on testing as larvae mature and move to the intestines. Another possible cause, pulmonary effects of filaria,[2] was not investigated during my stay. Approximately a third of the children in the outpatient department presenting with wheezing or coughing that had lasted longer than two weeks were also found to have helminth eggs in a single stool specimen during the one-month period.

These cases reminded me of an old teaching, "All that wheezes is not intrinsic asthma." In the West, where we see many patients from the Far East, Pacific and Central American regions where helminths are highly endemic, it would be well for us to remember to check for the presence of these parasites in new immigrants who wheeze, cough chronically or have